STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING _____ B. WING _____	R-C 09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the Investigation of Complaint IN00176650 and IN00175716 completed on August 7, 2015.

This visit was in conjunction with a PSR to the Investigation of Complaint IN00179129 completed on August 7, 2015.

This visit was in conjunction with the Investigation of Complaint IN00180481, IN00181438, and IN00181352.

Complaint IN00176650 - corrected
Complaint IN00175716 - corrected

Survey Dates: September 17, 18, 21 and 22, 2015

Facility number: 012466
Provider number: 155786
AIM number: 201014060

Census Bed Type:
SNF: 19
SNF/NF: 115
Total: 134

Census Payor Type:
Medicare: 19
Medicaid: 92
Other: 23
Total: 134

Allisonville Meadows was found to be in compliance with 42 CFR Part 483 , Subpart B and 410 IAC 16.2-3.1 in regards to the Post

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING _____ B. WING _____	R-C 09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Survey Revisit (PSR) to the Recertification and State License Survey and to the investigation of Complaint IN00176650 and IN00175716. Quality review completed by 30576 on September 25, 2015.	{F 000}		